STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 01 B. WING	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/16/12 Facility Number: 003075 Provider Number: 155695 AIM Number: 200364160 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Riverside Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a post certification review on or after March 17, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 93 and had a census of 84 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/21/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=D	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating as required by the construction type of Type V (111). LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any staff in the basement. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 from 2:40 p.m. to 2:45 p.m., there was a sixteen inch by twelve inch section cut out of both	K0025	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.The breaches in the basement ceiling have been appropriately patched to restore the one hour fire resistance rating as required.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored to ensure the deficient practice wil	03/17/2012

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	layers of drywall in the basement corridor ceiling. Also, there was a twelve inch by twelve inch hole cut out of both layers of drywall in the ceiling of the sprinkler riser room. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect two of seven smoke compartments. Finding include: Based on observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on	K0027	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. No residents were identified to be affected by this finding. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.The door coordinator on the smoke barrier doors near resident room 210 has been adjusted to allow the proper closing of the doors. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored	03/17/2012

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	02/16/12 at 1:15 p.m., the coordinating device on the smoke barrier doors near resident room 210 did not operate properly preventing the doors from closing completely leaving a six inch gap. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		to ensure the deficient practice wil not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 clean utility storage rooms with combustibles measuring over 50 square feet in size was provided with a self closing device. This deficient practice could affect any resident near the Heritage nurses' station. Findings include: Based on observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 at 12:45 p.m., the corridor door to the Heritage hall clean utility room measuring over 50 square feet in size with eighteen cardboard boxes of adult briefs lacked a self closing device.	K0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure one hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system protects hazardous areas. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.A self closing device was installed in the corridor door to the Heritage hall clean utility room. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored	03/17/2012

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	This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 assisted dining room exit access doors was readily accessible and unobstructed at all times. This deficient practice could affect any of the residents evacuated through the assisted dining room exit door. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 at 2:08 p.m., the exit door from the assisted dining room was labeled "Emergency Exit Only" and "Not an Exit." Additionally, the door had a deadbolt and a sliding latch bolt near the top of the door. Based on an interview with the Maintenance Supervisor and the Executive Director at the time of observation, neither could confirm whether the door was used as an emergency exit.	K0038	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure exit access is arranged so that exits are readily accessible at all times. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.To ease the signage confusion, the "Emergency Exit Only" sign was removed from the assisted dining room exterior door. We intend to maintain this door as "Not an Exit." What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance	03/17/2012

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	3.1-19(b)		Director, Executive Director and/or designee will be responsible for program compliance.	

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K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 2 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any residents on the 500 hall and any resident near the kitchen. Findings include: Based on observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 from 2:25 to 2:28 p.m., as viewed from outside of the	K0044	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure fire door sets are arranged to automatically close and latch. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.Positive latching hardware was installed on the fire door set by the Beauty Salon (500 Hall), and the kitchen fire door. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director or designeewill complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program	03/17/2012

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	facility, a block wall extended above the roof at the 500 hall and the kitchen cross corridor doors. Based on observation with the Maintenance Supervisor at 2:35 p.m. on 02/16/12, the 500 hall and the kitchen fire doors lack latching hardware and did not latch into the frame. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		compliance.	

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K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Monthly Fire Drill Report" with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 02/16/12 at 10:55 a.m., there was no record of a second and third shift fire drill for the fourth quarter of 2011. Based on an interview with the Maintenance Supervisor at the time of record review, the facility was without a Maintenance Supervisor in November and he was hired in December.	K0050	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure fire drills are held at unexpected times under varying conditions at least quarterly on each shift. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.A new Maintenance Director was hired in the Month of December, 2011, and fire drills have remained current.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will complete fire drills as required. Fire drill reports will be reviewed at each monthly Safety Committee Meeting.How will the corrective action(s) be monitored to ensure the deficient practice	03/17/2012

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	3.1-19(b) 3.1-51(c)		will not recur, i.e. what quality assurance program will be put into place?Fire drill reports will be reviewed monthly at the Safety Committee Meeting, and at the monthly CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 5 sprinkler heads in the 500 hall and 2 of 6 sprinkler heads in the Heritage Lounge were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the 500 hall and the Heritage Lounge in the event of a fire emergency. Findings include: Based on observations with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor	K0056	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure sprinkler heads are separated by at least six feet. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.PIPE Inc. removed one of the two sprinkler heads that were cited on the 500 hall that were within 12 inches of each other and one of the two sprinkler heads that were cited in the Heritage Lounge that were within three feet of each other.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance	03/17/2012

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	and the Director of Nursing on 02/16/12 between 12:40 p.m. and 1:13 p.m., the 500 hall had two sprinkler heads located twelve inches apart and the Heritage Lounge had two sprinkler heads located three feet apart. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		Director or designee will complete daily rounds throughout facility to maintain compliance.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 01 B. WING	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

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K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10			
	Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers on 100 hall and 1 of 3 basement fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers, Chapter 4-4.3. This deficient practice could affect any of the 32 residents on the 100 hall and any number of staff in the basement. Findings include: Based on observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 from 1:05 p.m. to 2:34 p.m., the maintenance tag on the 100 hall and the basement fire extinguishers indicated the last six year test was completed June 2005 and July 2005. This was acknowledged by the Maintenance Supervisor at the time of	K0064	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure portable fire extinguishers are provided in all health care occupancies. No residents were identified to be affected by this finding. Fire extinguishers have been tested per requirement.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.Fire Safety Co. performed the required 6 year test on the 100 hall and basement fire extinguishers that were cited.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director will keep a calendar of projected dates for ordering fire extinguisher testing and maintenance. Maintenance Director to annually review last date of testing and maintenance on each extinguisher.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months	03/17/2012

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	observation. 3.1-19(b)		and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted for staff and residents was maintained and the metal container with a self closing cover was used for an ashtray. This deficient practice could affect any residents evacuated through the employee's entrance. Findings include: Based on an observation with the	K0066	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure smoking areas are maintained and provided with a metal container with a self-closing cover. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.The area where smoking is permitted for residents and staff has been cleaned up	03/17/2012

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	Maintenance Supervisor on 02/16/12 at 11:40 a.m., the outside staff designated smoking area was provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts. At least one hundred cigarette butts were observed on the ground near the employee's entrance door in the smoking area. A metal ashtray was also provided at the entrance door but it was not equipped with self closing cover. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		and a metal ashtray with a self-closing cover was purchased and placed in the area.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director and or designee to complete daily rounds to ensure smoking area remains maintained and proper ashtray is in place.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 manual hood fire extinguishing activation devices was located in the path of egress. Section 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96 at Section 7-5.1 states, a readily accessible means for manual activation shall be located between 42 inches and 60 inches above the floor, located in a path of exit or egress, and clearly identify the hazard protected. This deficient practice could affect any kitchen staff and residents in the dining room. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 at 2:00 p.m., the activation device for the kitchen	K0069	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure cooking areas are protected with manual hood fire extinguishing activation device being located in a path of egress or exit. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.Fire Safety Co. relocated the manual hood fire extinguisher activation device to a path of egress or exit out of dietary.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director and or designee to complete monthly rounds to ensure proper location and maintenance of activation device.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive	03/17/2012

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	hood fire protection system was mounted on the wall above the preparation sink which was not in the path of exit or egress. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		Director and/or designee will be responsible for program compliance.	

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K0070 SS=E	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8			
	Based on observation and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any resident in the Cottage dining room. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 at 1:25 p.m., an electric fireplace with a heater was located in the Cottage dining room. Based on record review of the space heater policy with the Maintenance Supervisor at 11:25 a.m., the facility does not allow space heaters. 3.1-19(b)	K0070	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure that no portable space heating devices are located in health care occupancy areas. All residents on the Cottage were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.The heating mechanism for the fireplace in the Cottage was disabled by facility maintenance.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?The Maintenance Director and or designee to complete daily rounds to ensure heating element is not operable.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee	03/17/2012

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			for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be	K0144	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure that the off site fuel source for emergency generator is from a reliable source. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.A letter of reliability from NIPSCO meeting all of the requirements as outlined in NFPA 110 and ensuring the offsite fuel for the emergency generator was from a reliable source has been obtained and will be kept on file. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director and or designee will maintain letter of reliability and reliable source, and will review placement of letter monthly.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?A Life Safety CQI tool will be utilized monthly x 3 months and then	03/17/2012

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	required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview with the Executive Director and the Maintenance Supervisor on		quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Maintenance Director, Executive Director and/or designee will be responsible for program compliance.	

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	11/15/10 at 11:05 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) which was undated, but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, the low probability of interruption of the natural gas service and a signature of a technical person. This was acknowledged by the Executive Director and the Maintenance Supervisor during the time of record review. 3.1-19(b)			

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K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any resident in or near the Assistant Director of Nursing's office, resident room 103 and the MDS Coordinator's office. Findings include: Based on an observation with the Executive Director, Maintenance Director, Housekeeping/Laundry Supervisor and the Director of Nursing on 02/16/12 between 12:45 p.m. and 1:30 p.m., extension cords were noted in the following locations: a) a regular light weight	K0147	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the practice of this provider to ensure that all electrical wiring and equipment is in accordance with NFPA 70. No residents were identified to be affected by this finding.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this finding.All light duty extension cords were removed from the facility. A GFCI was installed in the medication room on the Liberty hall. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Daily rounds will be made by the Environmental Services Supervisor and/or designee to ensure no light duty extension cords have been placed.Staff in-serviced on observing new light duty extension cord(s) being put into use, removing the cord(s), and reporting to the Environmental Services Supervisor of finding.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put	03/17/2012

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	extension cord was plugged in and providing power for a refrigerator in the Assistant Director of Nursing's office b) a regular light weight extension cord was providing power to a lamp and another light weight extension cord was providing power to another lamp in resident room 103. c) a heavy weight extension cord was plugged in and providing power to a microwave and a refrigerator in the MDS Coordinator's office. This was acknowledged by the Maintenance Director at the time of observations. 2. Based on observation and interview, the facility failed to ensure 1 of 1 Liberty hall wet location staff medication rooms was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as areas subjected to wet conditions. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff.		into place?A Life Safety CQI tool will be utilized monthly x 3 months and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow-up.The Environmental Services Supervisor, Executive Director and/or designee will be responsible for program compliance.	

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	NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff using the Liberty hall medication room sink in the event of an electrical short. Findings include: Based on an observation with the Executive Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor on 02/16/12 at 1:40 p.m., the Liberty hall medication room had an electrical receptacle on the wall within three feet of the sink which was not provided with GFCI protection to prevent electric shock. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			